United States Department of Labor
Employees' Compensation Appeals Board

L.W., Appellant	)	
and	)	**Docket No. 19-1208**
	)	**Issued: July 19, 2019**
U.S. POSTAL SERVICE, SOUTHERN MARYLAND PROCESSING & DISTRIBUTION CENTER, Capital Heights, MD, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 12, 2018 appellant filed a timely appeal from an April 24, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees'

[1] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from April 24, 2018, the date of OWCP's last decision, was Sunday, October 21, 2018, with Monday, October 22, 2018 the first business day. Since using May 9, 2019, the date the appeal was received by the Clerk of the Appellate Boards would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is October 12, 2018, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1); *A.M.*, Docket No. 18-1098 (issued April 22, 2019).

Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

ISSUE

The issue is whether appellant has met her burden of proof to establish more than five percent permanent impairment of her bilateral upper extremities, for which she previously received schedule award compensation.

FACTUAL HISTORY

On October 24, 2012 appellant, a 46-year-old mail processor/distribution clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained carpal tunnel syndrome and tendinitis due to factors of her federal employment. On October 24, 2014 OWCP accepted the claim for bilateral carpal tunnel syndrome. It paid appellant intermittent wage-loss compensation on the supplemental rolls retroactive to October 16, 2012.[4]

Dr. Gary R. Smith, Board-certified in orthopedic and hand surgery, performed bilateral carpal tunnel decompression surgery on March 21, 2014. He performed revision of left median nerve decompression on April 27, 2015, and revision of right carpal tunnel decompression on August 24, 2015. On March 8, 2016 appellant returned to four hours of limited duty daily. She continued to receive partial disability compensation.

On December 7, 2017 appellant filed a schedule award claim (Form CA-7) and submitted an October 1, 2017 report in which Dr. Smith advised that she had reached maximum medical improvement (MMI). Dr. Smith noted that appellant had two electrodiagnostic studies, electromyography/nerve conduction velocity (EMG/NCV), and described her surgical history.[5] He indicated that she had a lot of scar tenderness, weakness, and ongoing pain with hypersensitivity in both palms and mild persistent dysesthesias in the fingertips. Dr. Smith advised that, in accordance with Table 15-23, Entrapment/Compression Neuropathy Impairment, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[6] appellant had eight percent right upper extremity permanent

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the April 24, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal. 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

[4] The record contains decisions dated September 16 and October 5, 2015 denying specific periods of disability in 2012.

[5] A May 18, 2011 EMG/NCV study demonstrated bilateral carpal tunnel syndrome with no evidence of acute C5 radiculopathy and right ulnar conduction delay at the elbow. An October 30, 2014 EMG/NCV study demonstrated moderate-to-marked severe bilateral median neuropathy at the wrist consistent with carpal tunnel syndrome, left more than right, and mild right ulnar compression neuropathy at the elbow.

[6] A.M.A., *Guides* (6th ed. 2009).

impairment and eight percent permanent impairment on the left upper extremity. He noted that the diagnosis of bilateral carpal tunnel syndrome had been confirmed electrodiagnostically and that, despite two previous decompressions on each side, appellant had ongoing symptoms. Dr. Smith found a clinical studies grade modifier (GMCS) of 3 for axonal loss, a functional history grade modifier (GMFH) of 3 for constant symptoms, a grade modifier of 3 for physical examination (GMPE) findings of ongoing weakness and decreased sensation, and a moderate functional scale of 3, for a combined eight percent permanent impairment of each upper extremity.

On January 31, 2018 OWCP referred appellant to Dr. Scott M. Tintle, Board-certified in orthopedic and hand surgery, for a second opinion and impairment evaluation. In a February 15, 2018 report, Dr. Tintle reviewed the medical record, a statement of accepted facts (SOAF), and a list of questions regarding appellant's permanent impairment. He provided examination findings indicating that when he initially tested two-point discrimination in the median and ulnar nerve distributions to both hands, appellant seemed uncooperative, but that eventually she had normal two-point discrimination of approximately six millimeters to all digits of bilateral hands. Dr. Tintle noted that she would not allow him to touch her carpal tunnel incisions because she stated they were very sensitive. Phalen's test did not reproduce any numbness into her fingers although it did cause her some discomfort. Dr. Tintle further noted that he had not performed a Tinel's test because appellant indicated that she was too tender. He advised that she demonstrated full range of motion (ROM) of her hands and thumbs and she had normal wrist, elbow, and shoulder ROM. Sensation was intact to the radial, median, and ulnar nerve distributions of appellant's bilateral hands. Dr. Tintle concluded that she was at MMI with regard to her bilateral carpal tunnel syndrome, that she had no need for further treatment, and that she had two percent permanent impairment of each upper extremity.

In an addendum dated March 14, 2018, Dr. Tintle advised that, in accordance with Table 15-23 of the A.M.A., *Guides*, appellant had a GMCS of 0, a GMFH of 3 because she described constant symptoms, and a GMPE of 0 as appellant's physical examination findings were nonphysiologic. He utilized these values to reach a final rating of grade 1 impairment, with a default value of two percent.

OWCP referred the medical record and a SOAF to Dr. Herbert White, Board-certified in preventive medicine and a district medical adviser (DMA). In a March 28, 2018 report, Dr. White reviewed Dr. Smith's October 1, 2017 report and Dr. Tintle's February 15 and March 14, 2018 reports. He advised that for each upper extremity, in accordance with Table 15-23, appellant had a GMCS of 3 for axon loss, a GMFH pf 3 for constant symptoms, and GMPE of 1 for pain, which yielded a grade 2 impairment with a default value of five percent for each upper extremity. Dr. White noted that a functional scale rating was not indicated as there was no *Quick*DASH score. He concluded that MMI was reached on October 1, 2017.

By decision dated April 24, 2018, OWCP granted appellant a schedule award for five percent bilateral upper extremity permanent impairment. The award ran for 24.4 weeks during the period January 20 to July 9, 2018. It accorded the weight of the medical evidence to the reports of the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the sixth edition of the A.M.A., *Guides*.[9]

The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[10]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[11] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories clinical studies, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale with an assessment of impact on daily living activities.[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of permanent impairment specified.[13]

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[14]

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[7] *Supra* note 2.

[8] 20 C.F.R. § 10.404.

[9] For decision issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used, *supra* note 6. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[10] *J.M.*, Docket No. 18-1334 (issued March 7, 2019).

[11] *Supra* note 6 at 449.

[12] *Id*. at 448-49.

[13] Federal (FECA) Procedure Manual, *supra* note 9 at Chapter 2.808.6(d) (March 2017).

[14] 5 U.S.C. § 8123(a); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019).

For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[15]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted appellant's claim for bilateral carpal tunnel syndrome. It granted her a schedule award for five percent permanent impairment of each upper extremity.

The Board finds that a conflict in the medical opinion evidence has been created between Dr. Smith, appellant's attending hand surgeon, and OWCP's referral physician and Dr. White, its DMA. Both physicians used Table 15-23 of the A.M.A., *Guides* in assessing appellant's upper extremity permanent impairment.

In an October 1, 2017 report, Dr. Smith opined that appellant had eight percent bilateral upper extremity permanent impairment. He noted that the diagnosis of bilateral carpal tunnel syndrome had been confirmed electrodiagnostically and that, despite two previous decompressions on each side, appellant had ongoing symptoms. Dr. Smith advised that appellant had a GMCS of 3 for axonal loss, a GMFH of 3 for constant symptoms, and a GMPE of 3 for ongoing weakness and decreased sensation, with a corresponding functional scale modifier of 3. He found a combined eight percent permanent impairment of each upper extremity.

In a March 14, 2018 report, Dr. Tintle advised that appellant had a GMCS of 0, a GMFH of 3 because she described constant symptoms, and a GMPE of 0 as her physical examination findings were nonphysiologic. He utilized these values to reach a final rating of a grade 1 impairment, with a default value of two percent for each upper extremity.

Thereafter, in a March 28, 2018 report, the DMA advised that for each upper extremity, appellant had a GMCS of 3 for axon loss, a GMFH of 3 for constant symptoms, and a GMPE of 1 for pain, which yielded a grade 2 impairment with a default value of five percent bilateral upper extremity permanent impairment.

The Board finds that a conflict exists between the opinions of Dr. Smith on behalf of appellant and the DMA, who had premised his report on the physical findings of Dr. Tintle. The Board finds the reports of Dr. Smith and the DMA to be of virtually equal weight resulting in a conflict which requires referral to an independent medical examiner.

As noted above, if there is a disagreement between an employee's physician and an OWCP referral physician, OWCP shall appoint a referee physician or impartial medical specialist who shall make an examination.[16] Consequently, as there is disagreement in this case, it must be referred to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding the extent of the permanent impairment of appellant's bilateral upper

[15] *A.I.*, Docket No. 19-0193 (issued May 1, 2019).

[16] *Supra* note 14.

extremities.[17] On remand OWCP should refer appellant, along with the case record and an SOAF, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion as to the extent of appellant's bilateral upper extremity permanent impairment. Following this and such further development deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the April 24, 2018 decision of the Office of Workers' Compensation Programs is a set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: July 19, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[17] *See C.H.*, Docket No. 18-1065 (issued November 29, 2018).